In this space, attach a recent photo, sized approximately 2" by 2", clearly picturing the applicant's face.

(FOR IDENTIFICATION PURPOSES ONLY)

APPLICATION FOR AIT PROGRAM

Return this completed form, with a check or Money Order for the application fee of $100, $25 Processing Fee, Fingerprint processing fee $56 (Total $181)-(payable to NHAP) to the following address:

Nursing Home Administrator Program
P.O. Box 997416, MS 3302
Sacramento, CA 95899-7416

PRINT OR TYPE

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER *
MAILING ADDRESS *(Number)*	*(Street)*		WORK TELEPHONE NUMBER ( )
(City)	*(County)*	*(State)* *(Zip Code)*	HOME TELEPHONE NUMBER ( )
E-MAIL ADDRESS (OPTIONAL)	**FAX NUMBER (OPTIONAL)**		DATE OF BIRTH

*Social Security Number Disclosure: Pursuant to Section 666(a)(13) of Title 42 of the United States Code and California Family Code section 17520, subdivision (d), the Department of Health Services (DHS) is required to collect social security numbers from all applicants for nursing home administrator licenses. Disclosure of your social security number is mandatory for purposes of establishing, modifying, or enforcing child support orders upon request by the Department of Child Support Services and for reporting disciplinary actions to the Health Integrity and Protection Data Bank as required by 45 CFR §§ 61.1 *et seq.* Failure to provide your social security number will result in the return of your application. Your social security number will be used by DHS for internal identification, and may be used to verify information on your application, to verify certification with another state's certification authority, for exam identification, for identification purposes in national disciplinary databases or as the basis of a disciplinary action against you.

ANSWER THE FOLLOWING QUESTIONS:

1. Are you a United States Citizen or a legal resident? ☐ YES ☐ NO

2. Are you at least 18 years of age or older? ☐ YES ☐ NO

3. Are you now, or were you, employed as a Nursing Home Administrator? (If "YES", fill in the information below.) ☐ YES ☐ NO

State: _____ License #: _____ Date of Expiration: _____

4. Former Names? (If "YES", list in space below) ☐ YES ☐ NO

a. _____

b. _____

c. _____

5. Have you ever pled guilty or nolo contendere to, or been convicted of any crime (other than minor traffic violations)? ☐ YES ☐ NO

IF THE ANSWER TO THIS QUESTION IS YES, EXPLAIN FULLY ON A SEPARATE SHEET OF PAPER. PROVIDE CERTIFIED COPIES OF ARREST REPORT AND COURT DOCUMENTS THAT INCLUDE THE FOLLOWING, AS APPLICABLE: CRIMINAL COMPLAINT, PLEA AND JUDGEMENT, AND PROBATION REPORT. IF THESE RECORDS HAVE BEEN DESTROYED, THE PROGRAM REQUIRES A SIGNED STATEMENT TO THAT FACT ON AGENCY LETTERHEAD, FROM THE AGENCY YOU ARE REQUESTING RECORDS. A CONVICTION WILL NOT NECESSARILY DISQUALIFY YOU.

6. Are you now or have you ever been licensed or certified by any other California state agency? (If "YES", please complete below) ☐ YES ☐ NO

Agency: _____. License #: _____. Date of Expiration: / /

Agency: _____. License #: _____. Date of Expiration: / /

Agency: _____. License #: _____. Date of Expiration: / /

**** CERTIFICATION—IMPORTANT—PLEASE READ BEFORE SIGNING—If not signed, this application may be rejected. ****

I certify under penalty of the perjury laws of the State of California that the information I have entered on this application (pg. 1-4) is true and correct. I further understand that any false, incomplete, or incorrect statements may result in denial of this AIT application and/or disqualification of the applicant's AIT hours with the Nursing Home Administrator Program. I authorize the employers and educational institutions identified on this application to release any information they may have concerning my employment or education to the State of California Nursing Home Administrator Program.

APPLICANT'S SIGNATURE **	DATE SIGNED **
✍	

APPLICANTS—DO NOT USE THE SPACE BELOW—FOR NHAP USE ONLY

FOR NHAP OFFICE USE ONLY

CASH. # _____	STATUS ☐ Approved ☐ Rejected ☐ Denied	
NHAP INITIALS _____	☐ Unopened Transcripts	☐ Training Outline
AMOUNT _____	☐ Fingerprints	☐ AIT # ☐ Preceptor Approved
	STAFF	DATE PROCESSED

NHAP AIT APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

5. EDUCATION

DID YOU GRADUATE FROM HIGH SCHOOL?		IF NOT, DO YOU POSSESS A GED OR EQUIVALENT?		IF NOT, ENTER THE HIGHEST GRADE YOU COMPLETED
☐ **YES**	☐ **NO**	☐ **YES**	☐ **NO**	

UNIVERSITY OR COLLEGE NAME--AND LOCATION. BUSINESS, CORRESPONDENCE, TRADE, TECHNICAL, OR SERVICE SCHOOL	COURSE OF STUDY	UNITS COMPLETED		DIPLOMA, DEGREE OR CERTIFICATE OBTAINED	DATE COMPLETED
		SEMESTER	QUARTER		

6. If you are applying for the AIT program on the basis of: (Check only one)

☐ Baccalaureate or higher degree, **complete only sections 7, 9 of this application.**

☐ Ten years of recent full-time work experience, as a registered nurse in a nursing home with at least the most recent five of the ten years of experience in a supervisory position, **complete only sections 8-9 of this application.**

☐ Ten years of full-time work experience, in any department of a nursing home, with at least the most recent five of the ten years of work experience in a supervisory capacity, and 60 semester units (or 90 quarter units) of college or university courses, **complete only sections 8-9 of this application.**

7. EMPLOYMENT HISTORY--*Begin with your most recent job. List each position separately.*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION
HOURS PER WEEK	TOTAL WORKED (Years/Months)	EMPLOYER NAME
TYPE OF BUSINESS		ADDRESS, CITY, STATE, ZIP
DUTIES AND RESPONSIBILITIES		

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION
HOURS PER WEEK	TOTAL WORKED (Years/Months)	EMPLOYER NAME
TYPE OF BUSINESS		ADDRESS, CITY, STATE, ZIP
DUTIES AND RESPONSIBILITIES		

NHAP AIT APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

7. EMPLOYMENT HISTORY *(Continued)*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION
HOURS PER WEEK	TOTAL WORKED (Years/Months)	EMPLOYER NAME
TYPE OF BUSINESS		ADDRESS, CITY, STATE, ZIP
DUTIES AND RESPONSIBILITIES		

8. NURSING HOME WORK EXPERIENCE *(Licensed NHA's, RN's, and Physicians. 10 yrs. work experience required)*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	
DUTIES AND RESPONSIBILITIES			

CHECK APPROPRIATE BOX

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM: / /	TO: / /
**** Signature of Licensed NHA, Physician, or RN** _____	**LIC. #** _____	**DATE:** / /

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	
DUTIES AND RESPONSIBILITIES			

CHECK APPROPRIATE BOX

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM: / /	TO: / /

** Signature of Licensed NHA, Physician, or RN _____	LIC. # _____	DATE: / /

NHAP AIT APPLICATION

APPLICANT'S NAME *(Last)*	*(First)*	*(M.I.)*	SOCIAL SECURITY NUMBER

8. NURSING HOME WORK EXPERIENCE *(Licensed NHA's, RN's, and Physicians. 10 yrs. work experience required)*

FROM *(M/D/Y)*	TO *(M/D/Y)*	JOB TITLE/CLASSIFICATION	SUPERVISORY? ☐ YES ☐ NO
HOURS PER WEEK	TOTAL WORKED (Years/Months)	FACILITY NAME	
DEPT. OF NURSING HOME		FACILITY ADDRESS, CITY, STATE, ZIP	

SUPERVISORY POSITIONS *(Include Responsibilities)*

CHECK APPROPRIATE BOX

☐ I am authorized and have personally verified the information from records on file at the facility.	FROM: / /	TO: / /
☐ I have personal knowledge of this work experience because I worked at the same facility as the applicant.	FROM: / /	TO: / /
**** Signature of Licensed NHA, Physician, or RN** _____	LIC. # _____	DATE: / /

9. TO BE COMPLETED BY PRECEPTOR

PRECEPTOR NAME *(LAST)*	*(FIRST)*	*(MIDDLE)*

NHA LICENSE NUMBER	PRECEPTOR NUMBER	PRECEPTOR EXPIRATION DATE

PRECEPTOR'S PRINCIPAL JOB(S) / TITLE(S)

NAME AND ADDRESS OF FACILITY, OFFICE OR CORPORATION

NAME, ADDRESS, AND PHONE NUMBER OF SNF / ICF WHERE TRAINING WILL TAKE PLACE

EXACT NUMBER OF HOURS PER WEEK AIT WILL BE TRAINING

EXACT NUMBER OF HOURS PER WEEK YOU AS THE PRECEPTOR WILL SPEND PERSONALLY SUPERVISING THE TRAINING OF THE AIT

☐ *Minimum* 20 ☐ 30 ☐ 40 ☐ 50 ☐ *Maximum* 60 ☐ *Other* _____

☐ **I have reviewed the application package and it is complete with the necessary attachments listed below.**

☐ 2 X 2 Photo	☐ Criminal Conviction Documentation	☐ $25 Processing Fee
☐ Unopened Transcript(s)	☐ 1,000 Hour AIT Outline	
☐ $100 Application Fee	☐ $56 Criminal Record Check Fee	

I declare under penalty of perjury under the laws of the State of California that the information furnished in section 9 is true and correct. I hereby agree to make it my personal responsibility to see that the Administrator-In-Training receives the type and amount of training required to make him/her fully qualified to become a licensed Nursing Home Administrator. I will comply with all the requirements of the AIT program, as set forth in the rules and regulations of the State Nursing Home Administrator Program (Health and Safety Code Chapter 2.35). I understand that failure to supervise the AIT as indicated above will result in the AIT's training hours being disqualified and may result in suspension of my CA Preceptor Certificate.

PRECEPTOR SIGNATURE _____	**DATE / /**

NHAP
AIT APPLICATION

(For Statistical Use Only)

APPLICANT: To assist NHAP in creating applicant statistical information, applicants are asked to voluntarily provide the following information. This questionnaire will be separated from the application prior to its review and will be kept confidential. Government Code Section 19705 authorizes the State to retain this information for research and statistical purposes.

AGE	GENDER
☐ (1) UNDER 21 ☐ (3) 21 - 39 ☐ (6) 40 - 69 ☐ (7) 70 AND OVER	☐ MALE ☐ FEMALE

Ethnic Category *(Please check the box that best describes your race/ethnicity.):*

☐ (7) **AMERICAN INDIAN OR ALASKAN NATIVE--**Persons having origins in any of the tribal peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ (2) **ASIAN--**Persons having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian Subcontinent. This includes China, Japan, and Korea.

☐ (1) **AFRICAN AMERICAN--**Persons having origins in any of the black racial groups.

☐ (8) **FILIPINO--**Persons having origins in any of the original peoples of the Philippine Islands.

☐ (4) **HISPANIC--**Persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

☐ (6) **PACIFIC ISLANDERS--**Persons having origins in the Pacific Islands, such as Samoa.

☐ (5) **CAUCASIAN--**Persons having origins in any of the original peoples of Europe, North Africa, or the Middle East.

Check if:

☐ (3) **OTHER** *(Specify)* _____

☐ (Y) **DISABLED—**A person with a disability is an individual who: (1) has a physical or mental impairment that substantially limits one or more life activities, such as walking, speaking, breathing, performing manual tasks, seeing, hearing, learning, caring for oneself or working,…; (2) has a record of such an impairment; (3) is regarded as having such an impairment.

☐ **MILITARY--**A military veteran; a widow or widower of a veteran; or a spouse of a 100% disabled veteran.

Why did you enter the AIT program?

☐ PRECEPTOR OR NHA ☐ EDUCATION / BACKGROUND IN LONG TERM CARE

☐ OWN A NURSING HOME ☐ OTHER _____

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE